STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00115048. Survey dates: August 27, 28, 29, 30 and 31, 2012 Facility number: 002574 Provider number: 155677 AIM number: N/A Survey team: Marla Potts, RN- TC Sharon Whiteman, RN Susan Worsham, RN Kim Perigo, RN Census bed type: SNF: 75 Total: 75 Census payor type: Medicare: 35 Other: 40 Total: 75 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	This plan of correction is to serve as Bell Trace Heath and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Bell Trace Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.The Bell Trace Health and Living Center respectfully requests that the submitted Plan of Correction be considered for a PAPER COMPLIANCE REVIEW.In reference to the annual health survey conducted at the Bell Trace Health and Living Center August 27th through August 31st, we are exercising our right to engage in the IDR process. We respectfully request a face to face Informal Dispute Resolution related to the assessment of 1 deficiencies identified in survey event id ALNY11. This deficiency is F329. The facility met the requirement for the regulation and disagrees with the assessment of the survey team for these deficiencies. When can the IDR be scheduled?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on September 10, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to provide care in a manner that promoted her dignity ,in that Resident # 42 was observed to wear an isolation gown over her clothing in public areas for 2 of 3 days of the survey. This affected 1 of 2 residents who met the criteria for dignity. Findings include: On 8/28/12 at 9:50 a.m. , Resident #42 was observed in her wheelchair in the open TV area next to the nurses' station with other residents watching TV. Resident # 42 was wearing a paper isolation gown. Interview with LPN #3 at 9:55 a.m., indicated that Resident #42 was starting to have some loose stools and has a history of Clostridium Difficile (C-diff). LPN #3 indicated it was the facility policy for residents with a diagnosis of C-Diff to wear the yellow gowns when they come out of their room.	F0241	F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1. Resident “42” is no longer in isolation.2. All current residents under Contact Isolation have been identified and none of these wear isolation gowns when out of their rooms.3. A systemic change will include that residents in Contact Isolation will be allowed out of their rooms without an isolation gown unless the Interdisciplinary Team or Physician deem it necessary. If an isolation gown is required, this will be identified in the plan of care. Education will be provided to all staff regarding the systemic change. 4. The Unit Manager or designee will monitor for residents that require Contact Isolation wearing isolation gowns when out of their rooms, 5 days a week for 30 days and then weekly for a duration of 12 months. Any concerns will be addressed.The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed. Completion Date:	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/28/12 at 2:00 p.m., Resident # 42 was observed sitting in front of the TV in the open area near the nurses' station. The resident was sleeping in her wheelchair. She was wearing a paper isolation gown and a pair of gloves. On 8/29/12 at 8:15 a.m., interview with the Unit Manager (UM) # 1 was conducted, regarding why Resident #42 was in a paper isolation gown in the public TV room near the nurses station. Unit Manager (UM) # 1 indicated that she was surprised that she was to wear the gown, "being a red flag," and that it was told to her by the higher ups this past Monday . On 8/29/12 at 2:00 p.m., on the same day that Unit Manager (UM) #1 indicated that she was mistaken on her previous comment. She indicated the DON stated that she thought it was best that the resident wear the gown out of her room to protect her from digging into her briefs. Observation of Resident #42 during the day of 8/29/12, indicated she was only picking at the top of her gown , not into her pants. 8/30/12 at 8:00 a.m., Resident #42		September 30, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed in her wheelchair in front of the TV located in the open TV room next to the nurses' station. The resident was wearing a paper isolation gown. 8/30/12 at 2 p.m., Resident#42 was observed without a paper isolation gown in front of the TV in the open area next to the nurses station Interview with LPN # 3, on 8/30/12 at 2:05 p.m., indicated that she was told that it was not needed anymore when the resident is out of room. The facility's C-Diff policy was provided by the Director of Nursing (DON) on 8/30/12 at 9:50 a.m. Review of C-Diff policy indicated there were no instructions for residents with said diagnosis of C-Diff for wearing a gown outside of their room. 3.1-3(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed related to checking the pulse prior to administration of Digoxin (heart medication) for 1 of 10 residents reviewed for unnecessary medications. Resident # 6. Findings include: Review of Resident # 6's clinical record on 08/29/12 at 10:00 a.m., indicated the following: An August 2012 physician's re-write order indicated Resident #6 had diagnoses which included, but were not limited to, failure to thrive, CAD [coronary heart disease], S/P [status post] bypass surgery; Ischemic Cardiomyopathy; Peripheral Neuropathy, and venous insufficiency of lower extremity. A phyican's re-write order for August	F0282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Resident “6” has an apical pulse checked prior to administration of Digoxin.2. All residents with current orders for Digoxin have been identified and are having an apical pulse checked prior to administration of Digoxin.3. The systemic change includes that all new orders and new admissions are reviewed at the morning Clinical meeting (Monday through Friday) for Digoxin orders and notation of the apical pulse on the MAR. In addition, the Unit Manager or Designee will review the MARs for notation of apical pulse per the schedule noted below.Education will be provided to licensed nurses regarding noting the apical pulse prior to administration of Digoxin.4. The Unit Manager or designee will audit all new orders and new admissions for notation of the apical pulse with administration of Digoxin. In addition, the Unit Manager or designee will audit all MARs for notation of an apical pulse prior to administration of Digoxin 5 days a week for 30 days, then weekly for a duration of 12 months. Any concerns will be addressed.The	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING _____ B. WING 00	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2012 indicated Resident #6 had orders for medications which included, but were not limited to, Digoxin 0.125 milligrams to be taken every morning for the diagnosis of Cardiomyopathy (disease of a heart muscle). This order was dated 12/11/08 and included instructions to hold the medication if the resident's heart rate was below 55. A July, 2012 medication record indicated Resident #6 received the Digoxin daily as ordered. The medication record indicated the resident's apical heart rate was to be checked and documented on the medication record. The dates of July 2 and July 14, 2012 lacked documentation supporting the resident's apical heart rate had been checked prior to giving the Digoxin medication. A June, 2012 medication record indicated Resident #6 received the Digoxin daily as ordered. The medication record indicated the resident's apical heart rate was to be checked and documented on the medication record. The dates of June 14, 18, and 25, 2012, lacked documentation supporting the resident's apical heart rate had been checked prior to giving the Digoxin		results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication. 08/31/12 at 8:55 a.m., the DON [Director of Nursing] was interviewed. The DON indicated she could not provide documentation supporting Resident #6's apical heart rate had been assessed on the 2 days in July, 2012 and the 3 days in June 2012 prior to nursing giving the resident his Digoxin. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure sliding scale insulin was administered in accordance with physician orders in order to control a resident's blood sugar, for 1 of 10 residents reviewed for medications. Resident #53 Findings include: Resident #53's clinical record was reviewed on 8/31/12 at 9:49 A.M. Diagnoses included but were not limited to Diabetes Mellitus. The current physician orders, dated 8/3/12, included orders of "Novolin R (insulin) per sliding scale at 6 A.M., of 111-150 2 units, 151-200- 4 units, 201-250 -6 units, 251-300- 9 units" and "Novolin R at 8 p.m. of 151-200 -2 units, 201-250-3 units, 251-300- 4 units, 301-300 -5 units" "Blood sugar 70 or below call MD (medical doctor)." (The units of regular insulin ordered	F0309	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Resident "53" is receiving sliding scale insulin in accordance with physician orders. 2. All current residents with sliding scale insulin orders have been identified and are receiving sliding scale insulin in accordance with physician orders. 3. The systemic change includes: · Sliding scale insulin orders will be written clearly on the MAR together with the dose, site, amount of insulin given. The Blood Glucose Log will only be used for blood glucose levels requiring physician notification. · All new orders and new admission orders are reviewed at the daily clinical meeting for sliding scale insulin and correct transcription to the MAR. · Unit Managers or designees will monitor the blood glucose log and the sliding scale insulin orders on the MARs for correct	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were based on the blood sugar results obtained.) The Blood Glucose Testing log indicated the following: 7/1/12 at 8 p.m., (BS) blood sugar results 172- 4 units given (should have been 2 units) 7/9/12 at 6 a.m., BS-66- no documentation of physician having been notified (physician should have been called) 8/4/12 at 8 p.m., (BS)152-4 units (2 units should have been given) 8/17/12 at 8 p.m., BS 174- 4 units given (2 units should have been given) 8/27/12 at 6 a.m., BS 66- no documentation of the physician having been notified.(Physician should have been notified) During interview with Unit Manager #1 on 8/31/12 at 9: 50 a.m., she indicated she had pulled the records yesterday and realized the nurses were giving the sliding scale insulin incorrectly and had not called the physician for the blood sugars below 70 as ordered. 3.1-37(a)		documentation of the amount of insulin given as well as physician notification of blood glucose levels outside of the ordered parameters per the schedule outlined below. Education will be provided to licensed nurses regarding the systemic change as mentioned above. 4. The Unit Manager or designee will review all MARs for accurate documentation of sliding scale insulin given in accordance with physician orders as well as documentation on the blood glucose log for levels requiring physician notification. This audit will be completed daily (Monday through Friday) for 30 days, then weekly for 30 days, then monthly for a total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident [Resident #264] who had a pressure sore received treatment and services in a manner to promote healing and prevent infection, in that licensed staff failed to maintain an established clean field for 2 of 2 observations of a clean dressing change. LPN #1 and LPN #2 Findings include: On August 29, 2012 at 10:10 a.m., Resident #264's clinical records were reviewed. An Admission Nursing Assessment, dated August 22, 2012 at 6:50 p.m., indicated a stage III pressure ulcer was present on Resident #264's	F0314	F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 1. Resident "264" is receiving treatment and services in a manner to promote healing and prevent infection. 2. All residents with a pressure ulcer have been identified and are receiving treatment and services in a manner to promote healing and prevent infection. 3. The systemic change includes that licensed nurses will have a competency check on establishing a clean field and proper storage and use of medication during treatment of a pressure ulcer upon hire, annually and as needed. Education will be provided to nursing staff regarding the systemic change above. 4. The Unit Manager or designee will audit for correct technique of	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING _____ B. WING 00	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coccyx [a small bone at the base of the spinal column]. A Skin-Pressure Ulcer Evaluation indicated, "Date of onset: 08/22/2012 [present on admission] Stage III: Full thickness tissue loss. Subcutaneous fat [tissue beneath the skin] may be visible but bone, tendon or muscle are not exposed." Physician's Orders dated August 22, 2012; indicated: "Cleanse open area to coccyx c [with] ns [normal saline], pat dry, apply Santyl [enzymatic ointment] to wound bed, apply Cuticern, cover c [with] foam, secure c [with] opsite, [symbol to change] q [every] day et [and] prn [as needed/necessary] soilage/dislodgement. Zinc Oxide [barrier ointment] apply to excoriation rectal area q [every] shift & prn till healed. Xenaderm [ointment] to bilateral lower extremities, feet, ankles, toes between et [and] under toes q [every] shift." On August 31, 2012 at 8:45 a.m., the Director of Nursing provided the nursing facility's Dressings, Dry/Clean		establishing a clean field and proper storage and use of medications during treatment of a pressure ulcer three times a week for 30 days, then weekly for 30 days, then monthly for a duration of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Level III policy dated October 2010. The policy indicated, "The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. ... Steps in the Procedure: 1. Adjust bedside stand to waist level. Clean bedside stand. Establish a clean field. 2. Place the clean equipment on the bedside stand." Taber's 19 Cyclopedic Medical Dictionary indicated, "Strict aseptic technique [method used to prevent contamination of the wound/standard precautions] is followed during dressing changes." Observation on August 29, 2012 at 10:30 a.m., LPN #1 implemented physician prescribed [dated August 22, 2012] wound and skin treatments. LPN #1 collected all the treatment supplies from a centrally located medication/supply area, which included the medications: Santyl, Zinc Oxide, and Xenaderm. The medications were observed to be stored in a tube, inside a box. LPN #1 established the clean field. After having established the clean field, LPN #1 positioned the tubed medications inside the box into the clean field. Plastic ampules of normal saline, opened and measured cuticern and opsite, and q-tipped			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication applicators were observed to be positioned on the clean field. After having completed the care to the wound on the coccyx, the care to the excoriation in the rectal area, and the care to the extremities, ankles, feet, and toes, LPN #1 properly disposed of all unused items. LPN #1 then took the three tubes of medications, put them back inside of the box, and returned the medications to the centrally located medication/supply area. Observation on August 30, 2012 at 10:15 a.m., LPN #2 implemented physician prescribed [dated August 22, 2012] wound and skin treatment. LPN #2 collected all the treatment supplies from a centrally located medication/supply area, which included the medications: Santyl and Zinc Oxide. The medications were observed to be stored in a tube inside a box. LPN #2 established the clean field. After having established the clean field, LPN #2 positioned the tubed medications inside the box into the clean field. Plastic ampules of normal saline, opened and measured cuticern and opsite, and q-tipped medication applicators were observed to be positioned on the clean field. After having completed the care to the wound on the coccyx and the care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the excoriation in the rectal area, LPN #2 properly disposed of all unused items. LPN#2 then took the two tubes of medications, put them back inside of the box, and return the medications to the centrally located medication/supply area. On August 31, 2012 at 9:50 a.m., Unit Manager #2 [manager for unit Resident #264 resided] was interviewed. During the interview, the observations dated August 29, 2012 at 10:30 a.m., and August 30, 2012 at 10:15 a.m., of physician prescribed wound and skin treatments were reviewed. Unit Manager #2, indicated LPN #1 and LPN #2 would not have been able to maintain the established clean field, when having positioned the three boxed medications into the clean field. On August 31, 2012 at 10:00 a.m., the Director of Nursing was interviewed. During the interview, the observations dated August 29, 2012 at 10:30 a.m., and August 30, 2012 at 10:15 a.m., of physician prescribed wound and skin treatments were reviewed. The Director of Nursing would not comment on LPN #1 and LPN #2 having maintained or not having maintained a clean field during wound clean dressing change as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated by the facility's Dressings, Dry/Clean Level III policy dated October 2010. 3.1-40(a)2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview, and record review, the facility failed to ensure G- tube placement was verified prior to medication administered, for 1 of 1 residents observed for medication administration. Resident #122 Findings Include: On 8/30/12 at 9:00 a.m., LPN # 2 was observed washing her hands, donning gloves, and then checking for gastric contents prior to administration of medications through Resident # 122's G- tube. LPN# 2 was also observed delivering Resident # 122's medications with tap water flushings in between medications. The facility's policy on Administering Medications through an Enteral Tube was provided by the Director of Nursing (DON) on 8/30/12 at 1:50	F0322	F 322 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS 1. Resident "122" has the G-Tube placement verified prior to administration of medication. 2. All residents with a G-Tube have been identified and are having the G-Tube placement verified prior to administration of medications. 3. The systemic change includes licensed nurses will receive a competency check for proper verification of G-Tube placement prior to administration of medication. This competency check will be completed upon hire, annually and as needed. Any concerns will be addressed. Education will be provided to licensed nurses regarding proper verification of a G-Tube placement prior to administration of medication. 4. The Unit Manager or designee will monitor the nurse verifying placement of the G-Tube prior to	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. On 8/31/12 at 8:30 a.m., review of facility's policy on Administering Medications through an Enteral Tube, #16 indicated instructions on checking placement on GT (G tube) by auscultating the abdomen and listening for the "whooshing" sound. Interview with LPN # 2 on 8/31/12 at 10:35 a.m., regarding the giving of gastric tube medications, she indicated that she would wash her hands, crush up the medications, re-wash her hands, pull back on syringe to check for placement (gastric contents noted) and give medications flushing with with tap water, give more medications, flush again and then re-wash her hands. She then indicated that she knew from nursing school that she was taught to listen with air first , and she did not know why she did not do it this time. 3.1-44(a)(2)		administration of medications 3 times weekly for 30 days, then weekly for 30 days, then monthly for a duration of 12 months. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review and interview, the facility failed to follow facility policy related to the cleaning of a handheld nebulizer for 1 of 1 residents observed for inhaler administration during medication pass and 1 of 1 nebulizer treatments. Resident # 256 Findings Include: Observation of RN#1 on 8/29/12 at 9:35 a.m., indicated RN #1 listened to breath sounds and checked vital signs prior to handing Resident #256 her handheld nebulizer treatment of Dubonex. RN # 1 stayed in the room with Resident #256 during procedure. After	F0328	F 328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 1. Resident "256" has their hand held nebulizer cleaned after use per facility policy. 2. All residents with hand held nebulizers have been identified and have their hand held nebulizer cleaned after use per facility policy. 3. The systemic change includes: · The facility policy for hand held nebulizers has been revised to include rinsing the unit with warm water after use. · Licensed nurses will receive a competency check for use of a hand held nebulizer to include rinsing the nebulizer after use with warm water. These competency checks will be completed upon hire, annually and as needed. Education will be provided to licensed nurses regarding the above mentioned systemic changes. 4. The Unit Manager or designee will monitor for cleaning of the hand	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	treatment was completed, RN#1 placed the nebulizer and tubing back into plastic bag without taking it apart or rinsing it out. RN #1 then reassessed Resident #256's lung sounds. A copy of the facility's policy was received from the Director of Nursing on 8/29/12. On 8/29/12 at 2:00 p.m., review of facility's policy regarding administration of handheld nebulizer included #22 on page 2 of the facility's policy on Administering Medications through a Small Volume (Handheld) Nebulizer, that when treatment was complete, to turn of nebulizer and disconnect T-piece, mouthpiece and medication cup. On 8/31/12 at 8:55 a.m., review of the Geriatric Medication Handbook 8th edition, it indicated that the cleaning of the nebulizer includes rinse with warm water after each use.		held nebulizer after use per facility policy 3 times a week for 30 days, then weekly for 30 days, then monthly for a total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-47(a)(6)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure medications were being adequately monitored for 3 of 10 residents reviewed for unnecessary medication. Resident #13, #263, and #264 Findings include: 1. Resident #264's clinical records were reviewed on August 29, 2012 at 10:10 a.m.	F0329	F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1. Residents #13, #263, and #264 have their medications monitored and reviewed for unnecessary medications. Resident #264 has been scheduled for an ECG and has their apical pulse rate monitored and documented prior to receiving their Digoxin. Resident #263 had a Valproate level drawn and has routine orders for a level per MD orders. Resident #13 has an	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #264's diagnoses included but were not limited to diastolic and congestive heart failure [inability of the heart to circulate blood effectively], chronic atrial fibrillation [cardiac/heart arrhythmia (irregular heart action)], and stenosis of the mitral and aortic heart valves [narrowing of orifices between blood chambers, which causes impairment of blood flow]. Physician's Orders dated August 26, 2012; indicated, "trazodone [antidepressant] 50mg hs [hour of sleep]." The 2010 Nursing Spectrum Drug Handbook indicated, "Precautions: use cautiously in cardiovascular disease .... elderly ... Patient monitoring ... monitor ECG [a record of the electrical activity of the heart]." Continued review of Resident #264's clinical records lacked documentation, which indicated monitoring of cardiovascular status. On August 30, 2012 at 11:00 a.m., the Director of Nursing provided a copy of the facility's Psychotropic Drug Use policy which indicated, "Medications classified as psychopharmacological drugs will be		ECG scheduled. 2. All residents receiving Trazadone and Prozac have been identified and reviewed for the need of an ECG or other means of cardiovascular monitoring such as routine vital signs if cardiovascular disease is present. All residents receiving Digoxin have been identified and are receiving an apical pulse prior to administration of the medication. All residents receiving Depakote have been identified and have orders for Valproate levels. 3. The systemic change includes: · All new orders and new admission orders are reviewed at the daily clinical meeting (Monday through Friday) to include new orders for Trazadone, Prozac, Digoxin and Depakote. A review of the MAR for inclusion of an Apical pulse with Digoxin is included with this review. In addition, any new orders for Trazadone and Prozac will include a review for cardiovascular disease and communication with the physician for an ECG if necessary or other means of cardiovascular monitoring such as routine vital signs. Orders for Depakote will include a review for a baseline level for Valproate and routine lab levels per the same per MD order. Education will be provided to licensed nurses regarding the systemic change. 4. The Unit Manager or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monitored in accordance with Federal Standards." August 31, 2012 at 8:45 a.m., the Director of Nursing indicated a system was not in place to monitor cardiovascular status for a resident taking antidepressant medication. Resident #264's Physician Orders dated August 22, 2012, indicated, "digoxin [cardiac anti-arrhythmic] 250mcg ... Q [every] day." The 2010 Nursing Spectrum Drug Handbook indicated, "digoxin ... Patient monitoring: assess apical pulse rate [heart beats per minute] regularly for 1 full minute. If rate less than 60 beats/minute, withhold dose and notify prescriber." Resident #264's Medication Administration Record lacked documentation a pulse had been assessment prior to the administration of digoxin on August 23, 24, 25, and 27, 2012. On August 29, 2012 at 1:20 p.m., Unit Manager #2 [manager for unit Resident #264 resided] was interviewed. During the interview, Unit Manager #2 indicated a resident's pulse is to be assessed		will audit: · All MARs for notation of an apical pulse prior to administration of Digoxin 5 days a week for 30 days, and then weekly for a duration of 12 months. · Completion of an ECG or other cardiovascular monitoring such as routine vital signs for residents receiving Trazadone or Prozac weekly for 30 days, then monthly for a duration of 12 months. · Completion of a baseline level for Valproate and routine lab levels per MD order for residents receiving Depakote, weekly for 3- days, then monthly for a duration of 12 months of monitoring. · Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	prior to administration of digoxin. If the heart rate is below 60 beats per minute, the medication is to be held. Unit Manager #2 further indicated, August 23, 24, 25, and 27,2012 documentation was lacking, which indicated Resident #264's pulse had been assessed prior to digoxin administration. 2. Resident #263's clinical records were reviewed on August 29, 2012 at 9:20 a.m. Resident #263's diagnoses included but were not limited to bipolar disorder and mixed dementia. Physician orders dated August 24, 2012 [admission]; indicated, "Depakote ER [extended release] 500mg i [one] ... Q [every] a.m. Depakote 1,000mg i [one] ... Q [every] HS [hour of sleep]." A total of 1500mg per day. The 2012 Nursing Spectrum Drug Handbook indicated Depakote is an anticonvulsant [Resident #263's clinical records lacked documentation which indicated a diagnosis of seizure disorder] which can also be used for mood stabilization. "Dosage adults			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(mood stabilization) initially 750mg PO [by mouth] daily in divided doses. Titrate rapidly to desired effect or trough level of 50 - 100mcg/ml ... Patient monitoring ... monitor valproate [depakote] blood level; therapeutic range is 50 - 100mcg/ml." Continued review of Resident #263's clinical records lacked documentation, which indicated monitoring of valproate blood levels. On August 31, 2012 at 10:00 a.m., the Director of Nursing indicated having checked with the acute care hospital Resident #263 was transferred from and having reviewed current laboratory records and no current, nor past valproate blood levels were available. 3. Resident #13's clinical records were reviewed on August 29, 2012 at 8:40 a.m. Resident #13's diagnoses included but were not limited to atrial fibrillation [cardiac/heart arrhythmia (irregular heart action)]. A Physician's order dated August 07, 2012 at 1:30 p.m., indicated; "Prozac [antidepressant] 10mg ... QD			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[everyday] x [times] 2wks [two weeks] then Prozac 20mg .... QD. The 2010 Nursing Drug Spectrum Handbook indicated, "Precautions: use cautiously in ... cardiovascular disease ... Patient Monitoring ... Monitor cardiovascular status, particularly for prolonged QT interval." Continued review of Resident #13's clinical records, the records lacked documentation which indicated monitoring of cardiovascular status. On August 30, 2012 at 11:00 a.m., the Director of Nursing provided a copy of the facility's Psychotropic Drug Use policy which indicated, "Medications classified as psychopharmacological drugs will be monitored in accordance with Federal Standards." August 31, 2012 at 8:45 a.m., the Director of Nursing indicated a system was not in place to monitor cardiovascular status for a resident taking antidepressant medication. 3-1-48(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on interview and record review, the facility failed to ensure pharmacy recommendations were acted upon for 3 of 10 residents reviewed for medications. Resident's #119, #77, and #6 Findings include: 1. Resident #119's clinical record was reviewed on 8/29 at 8:22 A.M. Diagnoses included but were not limited to "depression and anxiety." Current physician orders, dated 8/10/12, included an order for "Lexapro 50 mg (for depression) one tablet daily. " This was dated to have been started 5/2011. A pharmacy recommendation, dated 5/21/12, indicated "(residents name) is receiving Lexapro 5 mg tablet orally every day and is due for a GDR (gradual dose reduction) attempt unless contraindicated, if	F0428	F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 1. Resident's #119, #77, and #6 have had their pharmacy recommendations acted upon and reviewed with the attending physicians. Resident #119 has had a gradual dose reduction of the Lexapro. Resident #77's Pravachol has been changed to hs and one of the multivitamins have been discontinued. Resident #6 has had a gradual dose reduction of the Lexapro. 2. All pharmacy consultant recommendations for the last 90 days have been reviewed and any recommendations have been acted upon. 3. The systemic change includes: · The pharmacy consultant will exit the building with the Director of Nursing or designee after the monthly visit to discuss any recommendations. · The Director of Nursing will forward the recommendations to	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contraindicated please indicate at reason...decrease Lexapro to 5 mg orally every other day for 2 weeks then discontinue or ....A GDR is contraindicated due to_____." This had not been responded to by the physician. Social service notes, included a form labeled "Psychotropic Medication/Behavior Management Review," dated 8/3/12, which indicated "will request Lexapro (antidepressant) qod from MD," "Pharmacy recommendation to decrease to every other day sent to Dr... (name of physician) call Dr (name) to request ok or that it is contraindicated." The review form, dated 7/11/12, indicated "pharmacy rec (recommendation) to Dr...5/15/12," "request decrease and then discontinue of lexapro." The review form, dated 5/18/12, indicated current medication Lexapro 5 mg, request Lexapor every other day times 2 weeks than discontinue or as Physician recommends." During interview with the Social Service Director on 8/29/12 at 8:51 A.M., she indicated she kept bringing the note forward concerning the drug reduction because as far as she knew		the attending physicians within 72 hours. If the physician has not responded to the recommendations within 48 hours, the recommendations will be acted upon by the Medical Director. Education will be provided to licensed nurses regarding the above systemic change. 4. The Administrator or designee will monitor for the pharmacy consultant exiting with the Director of Nursing or designee monthly for a duration of 12 months. The Director of Nursing or designee will monitor for the attending physician notification within 72 hours of submission of the pharmacy consultant reports and response by the physician within 48 hours as well as submission to the Medical Director if the attending physician has not responded within 48 hours. This monitoring will continue monthly. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the physician had never responded to the request made 5/21/12. She indicated it was brought up in care plan meetings each time and nurses were present. During interview with the Director of Nursing, on 8/29/12 at 2:00 P.M., she indicated the Medical Director would address this as the resident's physician was hard to get to respond to recommendations. She indicated the Unit Manager had called the physician and sent the recommendation, but this had not been documented anywhere. 2. Resident #77's clinical record was reviewed on 8/30/12 at 945 a.m. A pharmacy recommendation note in the chart indicated a recommendation had been made 8/21/12, with notes of "pravachol time and 2 multi vitamins." During interview with Unit Manager #1, on 8/30/12 at 10:30 A.M., she indicated the Director of Nursing (DON) was calling the pharmacist for the recommendation as it apparently was not left at the facility. During interview with the Director of Nursing, on 8/30/12 at 10:30 A.M., she indicated she phoned the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pharmacist and the recommendations had not been sent yet. She indicated this was an oversight. She indicated the pharmacist had just now faxed the recommendations and provided the recommendations for this resident. The DON indicated the recommendations were sent to her and the Assistant Director of Nursing by the pharmacist after the pharmacist had visited the facility and it had just been overlooked at this time. The pharmacy recommendations for Resident #77, dated 8/21/12, indicated recommendations dated 8/21/12, for "change Pravachol 10 mg to hour of sleep to optimize the effectiveness" and "is currently receiving two multivitamins, would it be appropriate to DC (discontinue) one of them?" 3. Review of Resident # 6's clinical record on 08/29/12 at 10:00 a.m., indicated the following: A physician's re-write order for August 2012 included an order for Escitalopram (generic of Lexapro/antidepressant medication) 5 milligrams to be taken every other day. This order was dated 02/14/12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Quarterly MDS (Minimum Data Set) assessment, dated 06/21/2012, indicated Resident #6 had cognitive impairment with poor decision making skills, had no behaviors, and required extensive assistance with all care. Resident #6's August 2012 medication record was reviewed on 08/30/12 at 10:20 a.m. The medication record indicated Resident #6 had continued to receive Escitalopram as ordered. The August 2012 physician's re-write order indicated Resident #6 had diagnoses which included but were not limited to, failure to thrive, coronary artery disease, Cardiomyopathy and depression. Review of pharmacy recommendations indicated a recommendation had been made on 8/21/12 for the medication of Escitalopram. Written on the recommendation was "Lex GDR [gradual dose reduction]." Interview of LPN #2 on 08/30/12 at 12:00 p.m., indicated "Lex GDR" was a recommendation for Lexapro. Interview of LPN #2 on 08/30/12 at 12:55 p.m., indicated the last			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reduction for Lexapro was when it was reduced to every other day. LPN #2 indicated the DON [Director of Nursing] was looking for the full recommendation and order for the Lexapro. On 08/30/12 at 1:00 p.m., the DON provided a copy of a pharmacy form titled "Note to Attending Physician/Prescriber." This form indicated, "[name of Resident #6] is receiving Lexapro 5 mg (milligrams) tab po [by mouth] every OTHER day. He is due for a GDR attempt unless contraindicated. If contraindicated, please indicate a reason. Since the 5 mg tab is the lowest available dose, may we DC [discontinue] it." This form was dated 08/21/12. Interview of the DON on 08/30/12 at 1:00 p.m., indicated the DON had just received the recommendation "today." The DON indicated the resident's physician was not aware of the recommendation. The DON indicated there had been no change in the Lexapro and the resident was still receiving it as ordered. The Social Services Director (SSD) was interviewed on 8/30/12 at 1:25 p.m. The SSD indicated the last reduction of Resident #6's Lexapro			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was last February when it was decreased to every other day. The SSD indicated she wasn't aware of the last (08/21/12) recommendation to DC the Lexapro. The SSD indicated she just tracked the psychoactive medications so wouldn't be aware if any other dose reductions. The SSD indicated other medication reductions would go through nursing via pharmacy recommendations. 3.1-25(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and record review, the facility failed to ensure 2 of 2 Emergency Drug Kits (EDK) observed in the Skilled 1 medication	F0431	F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. The Emergency Drug EDKs on	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	room were locked. Findings Include: On 8/29/12 at 10:15 a.m., in the Skilled 1 station medication room with Unit Manager(UM) #1), the (Emergency Drug Kit (EDK) box in the Skilled 1 station medication storage room refrigerator was not locked and it contained 2 vials of lorazepam liquid ,2mg/ml and 2 lorazepam 2mg /ml- 2 injectable's. Interview with UM #1 regarding if EDK's were to be locked per policy and she stated, yes . Observation at 10:30 a.m., on 8/29/12 of the Skilled 1 medication storage room noted that the Table Top EDK was not locked. Interview with UM #1, at that time, indicated it was supposed to be locked, also. The facility's Emergency Drug kit policy was provided by the Director of Nursing (DON) on 8/30/12 at 1:50 p.m. Record review of Emergency Drug Kit (EDK) facility policy, procedure #6 on page 1 indicated that EDK's sealed by pharmacy will bear a red seal. Additional black seals will be placed inside the kit for use in re-sealing the		the Skilled One Medication Room have been locked per facility policy. 2. All Emergency Drug EDKs are kept locked per facility policy in all medication rooms. 3. The Systemic Change includes: · At the time of the nurse removing the lock on the EDK, a black lock will be immediately replaced on the container. · Each shift shall note that the EDK is locked per facility policy during the shift to shift controlled substance count. · The Unit Manager or designee will review the EDKs on her Unit daily for confirmation of a lock being present on all EDKs on her unit. Education will be provided to licensed nurses regarding the systemic change. 4. The Unit Manager or designee will audit for a lock present on the EDK daily for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	EDK whenever it is opened. 3.1-25(m)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure a resident's medications were accurately documented on medication administration record for 1 of 10 residents reviewed for medication administration. Resident # 6 Findings include: Review of Resident #6's clinical record on 08/29/12 at 10:00 a.m., indicated the following. An August 2012 physician's re-write order included an order for Escitalopram (generic for Lexapro/an antidepressant medication) 5 mg (milligrams) to be given to Resident #6 every other day. This order was	F0514	F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 1. Resident #6's medications are accurately documented on the medication administration record for August. 2. All medication administration records were reviewed during the September monthly review of the administration records for accuracy. Any concerns were addressed. 3. The systemic change includes: · All new admission orders and new orders are reviewed at the daily (Monday through Friday) clinical meeting for accuracy of documentation on the Medication Administration Record. · All medication administration records will be reviewed by 2 nurses during the monthly "change over"	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 02/14/12. Review of a July 2012 medication order indicated the Escitalopram had been signed out as given every day for the month of July. A physician's re-write order for August 2012 indicated Resident #6 had diagnoses which included, but were not limited to, failure to thrive and Depression. On 08/31/12 at 8:30 a.m., the Director of Nursing (DON) provided a copy of a pharmacy transaction indicating 18 Escitalopram tablets were delivered from the pharmacy for the month of July. Interview of the DON on 08/31/12 at 8:30 a.m., indicated the resident could not have received the medication daily due to there was not enough of the Escitalopram tablet to be given daily. The DON indicated someone must have seen the blank spaces and filled them in. The DON indicated she was not aware of the documentation error prior to the survey. 3.1-(50)(a)(1)		with a review of the MD orders and correct transcription onto the medication administration records. This will be confirmed by 2 nurses signing the monthly physician orders signifying that the orders and transcription are correct. Education will be provided to licensed nurses regarding the systemic change. 4. The Unit Manager or designee will audit for accuracy of transcription onto the medication administration record for all new orders and new admission orders daily (Monday through Friday). In addition, the Unit Manager or designee will audit 5 random resident medication administration records for accuracy monthly for a duration of 12 months. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	State Rule Findings 3.1-14 PERSONNEL (t). At the time of employment or within one (1) month prior to employment and at least annually thereafter, employees and nonpaid personnel of facilities should be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the proceeding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure each employee who did not have a documented negative tuberculin skin test during the preceding twelve months received a two-step	F9999	F9999 FINAL OBSERVATIONS State Rule Findings 3.1-14 PERSONNEL 1. Employee #1 has received a 2 step tuberculosis screen which was negative. 2. All employees' files have been audited and all newly hired employees have received a two-step tuberculosis screen as necessary per policy. 3. The systemic change includes: · All newly hired employees who do not have a documented negative tuberculin skin test during the preceding twelve months will have a tuberculosis screen upon hire and complete a two-step tuberculosis screen. This will be recorded upon hire and the initial test read prior to the employee starting. Within 7 – 10 days after the initial test, a second step will be completed. The Human Resources Director will confirm that a PPD has been administered at the general orientation process and again for reading prior to starting the job specific orientation. The HR Director will again provide an audit within 14 days of employment to confirm receipt and reading of the 2 nd step PPD. · A log has been devised to track all employee PPDs. This log will be reviewed weekly at the daily department head meeting for	09/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tuberculosis screen for 1 of 5 employees hired in the past four months whose records was reviewed. (General Employee # 1) Findings include: On August 31, 2012 at 9:00 a.m., the Administrator provided a copy of the nursing facility's Pre and Post Employment Health Screen [not-date], which indicated "This policy is designed to proved a means of protection for patients and staff members against communicable disease and work-related infections. ...Testing for active tuberculosis is accomplished using the two step Mantoux tuberculin test method recommended by the Centers for Disease Control." Review on August 30, 2012 at 10:00 a.m., of General Employee (title given by facility) # 1's personnel records indicated the date of hire as May 04, 2012. The records lacked documentation of a negative tuberculin skin test during the preceding twelve months. A tuberculin skin test was administered		completion of 2 nd step PPDs of new employees. Education has been provided to the HR Director regarding the systemic change. 4. The HR Director or designee will audit all new employee files upon hire for initial PPD and within 2 weeks after hire for completion of the 2 nd step PPD. This audit will continue indefinitely. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on April 30, 2012 at 9:30 a.m. A reading, dated May 3, 2012, indicated a negative tuberculin skin test. The records lacked documentation a second step had been implemented. Interview on August 31, 2012 at 8:45 a.m., with the Human Resource Director indicated General Employee # 1 should have had a second step tuberculin skin test one to three weeks after the April 30, 2012, test and did not. 3.1-14(t)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155677	A. BUILDING 00 B. WING	08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TRACE HEALTH AND LIVING CENTER	725 BELL TRACE CIR BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE